UNITED
NATIONS

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Economic and Social Council

Distr.
LIMITED

E/ICEF/1990/P/L.2
12 February 1990

ORIGINAL: ENGLISH

UNITED NATIONS CHILDREN'S FUND
Programme Committee
1990 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Botswana

The Executive Director recommends that the Executive Board approve an amount of $2,500,000 from general resources, subject to the availability of funds, and an amount of $5,183,000 in supplementary funds, subject to the availability of specific-purpose contributions, for the country programme of Botswana for the period 1990-1994.

* In order to meet documentation deadlines, this document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme co-operation at the end of 1989, will be contained in the "Summary of 1990 recommendations for general resources and supplementary funding programmes" (E/ICEF/1990/P/L.1).

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THE SITUATION OF CHILDREN AND WOMEN

1. In the past three decades, Botswana has made significant strides in meeting the needs of children and women. According to the second family health survey undertaken by the Central Statistics Organization in 1988, the infant mortality rate (IMR) dropped from 119 per 1,000 live births in 1960 to 37 per 1,000 live births in 1988. During the same period, the under-five mortality rate (U5MR) dropped from 174 per 1,000 live births in 1960 to 52 per 1,000 live births by 1988. At least 85 per cent of the total population lives within 15 kilometres of a health facility, while the remaining 15 per cent can be reached through mobile services. Sparse population distribution and settlement patterns have made it difficult to reduce further the reach of health facilities. Almost 90 per cent of the population has access to clean water in the villages, and the figure rises to 100 per cent in urban areas. Over 85 per cent of all primary-school-age children attend school, and a portion of the remaining 15 per cent attend non-formal classes.

2. Despite the severity of the recent six-year drought (1981/1982-1986/1987), malnutrition was significantly reduced during the reporting period, principally as a result of the implementation of an effective and broad-based drought relief programme that included the feeding of malnourished children, supplementary feeding of vulnerable groups, agricultural support schemes and labour-based relief projects to supplement loss of income caused by the drought. In recognition of the country's exemplary drought relief effort, the President, Dr. Quet Masire, received the 1989 Hunger Award.

3. The implementation of the drought relief programme coincided with the accelerated implementation of primary health care (PHC) interventions, particularly immunization and the control of diarrhoea-related dehydration through the use of measures such as oral rehydration, which contributed to the reduction of malnutrition, as well as childhood morbidity and mortality. Progress was also registered in the area of fertility reduction, with a total fertility rate of 5.0 in 1988 as compared with 7.1 in 1981.

4. However, there is a real danger of a reversal of the gains made in reducing child morbidity and mortality. With the return of the rains there has been an increase in the incidence of water-related diseases such as malaria and diarrhoea, which take a high toll on the lives of young children. The end of the drought has also marked the end of drought relief for vulnerable groups. Ways must be found to replace the drought relief with sustainable programmes to help poor households (60 per cent of the total) to ensure the survival and development of their children.

5. Although Botswana has made considerable social advances in the past two decades, the degree to which the country can mobilize the resources required to accomplish future child survival and development (CSD) goals depends very much on actions that will be taken in the current programme period, 1990-1994. The mid-term review of the Sixth National Development Plan (1985/1986-1990/1991) stressed that, while the current economic situation was healthy, by the mid-1990s the situation was expected to change dramatically. By that time, it is envisaged that increasing demands for services and the growth in recurrent costs will exceed, on a regular basis, the Government's ability to support these costs. By then,

Botswana will have less room to manoeuvre than the present economic situation might suggest. How the Government responds to social sector demands under these conditions will therefore be critical to the maintenance of existing levels of service delivery, as well as for expansion into priority areas of unmet demand.

6. The situation is even more critical when one considers that even the rapid economic growth of the 1970s and 1980s has had only a moderate impact on the pervasive poverty facing the majority of the country's population. A 1988 household income and expenditure survey suggested that approximately 60 per cent of all rural households were unable to meet all of their basic human needs.

7. In this context, it is important to note the considerable earning power differentials between male- and female-headed households, the latter making up more than one third of all households. The differential is 2.6:1 for urban areas and 1.8:1 for rural areas, and this holds across educational levels. Women in general, and female-headed households in particular, suffer from poverty to a greater extent than do others, while remote-area dwellers (those living in communities of less than 500) face perhaps the most difficult situation. Remote-area dwellers (about 40,000, or 3 per cent of the population) are dependent on food supplementation to meet 90 per cent of their nutritional needs. Hunting restrictions, patterns of land ownership and migration, combined with almost non-existent job opportunities, have seriously undermined the ability of the remote-area dwellers to meet these needs.

8. The recent drought starkly points up the underlying level of household food and economic insecurity. Presumably as a result of drought relief feeding programmes, levels of moderate malnutrition actually declined during a period of severe drought, from 30 per cent in 1984 to 15 per cent in 1988. This has served to reorient attention towards household food and economic security issues, especially when those factors which undermined production and purchasing power prior to the drought (loss of cattle and other productive assets, loss of earning potential and loss of informal on-farm and off-farm rural employment) were intensified by the drought. The potential for employment will be even more restricted in the 1990s, and the informal sector offers a poor alternative. Agricultural self-sufficiency is limited by farming systems and climatic considerations and, in any case, such production is inadequate for the needs of marginal households lacking labour, particularly female-headed households.

9. The Government has undertaken major research and extension initiatives designed to support smallholder development (e.g., the Arable Lands Development Programme, the Accelerated Rain-fed Arable Programme and various horticultural projects) and has established a national food strategy that is being revised to include concerns about household food and income security of the poorest, in addition to the initial focus on overall food production.

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PROGRAMME CO-OPERATION, 1987-1989

10. UNICEF support to Botswana for the previous co-operation period included a commitment of $1,285,000 from general resources. The programme focused mainly on health, nutrition, education, social mobilization and social statistics. In addition, supplementary funds in the amount of $2,504,860 were received from the Governments of the United Kingdom, the Federal Republic of Germany, Finland, the Netherlands and Canada and from the Japan Committee for UNICEF, the Bernard Van Leer Foundation and the Canadian Committee for UNICEF. The close co-operation between the Government, UNICEF, representatives of other United Nations agencies and non-governmental organizations (NGOs) has permitted the regular review of programme implementation, timely response to problems thus identified and adequate co-ordination between the various parties involved.

Expanded programme on immunization

11. Universal child immunization (UCI) was achieved by December 1988 through an immunization acceleration strategy that centred on the use of house-to-house coverage and channelling surveys in each district in order to identify defaulters by name, antigen and health facility catchment area. Those surveys had the unique characteristic of combining the art of social mobilization with the science of project evaluation, decentralized to the communities. They allowed for the analysis of different project implementation problems in various communities, thus facilitating corrective action specific to each community. The reported death rates from measles and whooping cough in 1988 was zero. There were no cases of poliomyelitis or diphtheria, while there was only one reported case of neonatal tetanus.

Growth monitoring and nutrition surveillance

12. Nutrition surveillance activities have progressed satisfactorily, primarily because of the acknowledged importance of surveillance data as a component of the drought early warning system. Child growth monitoring and promotion, while in use since the early 1960s, is not as well understood, however, and there is a tendency among health workers to confuse the objectives of growth monitoring with those of nutrition surveillance. The evaluation reports of both the nutrition surveillance and growth monitoring and promotion programmes have made important suggestions for improvements. These have been taken into consideration in developing the proposed country programme. In particular, efforts are needed to make growth monitoring and nutrition surveillance programme activities more community-based.

Breast-feeding and sound weaning practices

13. UNICEF has supported the promotion of breast-feeding and sound weaning practices through seminars and workshops for health workers and for the training of trainers. The proportion of mothers who breast-feed remains high. Urban mothers tend to wean their babies much earlier, however. Furthermore, the lack of a code on breast milk substitutes, together with limited maternity leave benefits for working women, threatens to erode the high levels of breast-feeding, especially in urban areas. Work continues on the possibility of the local manufacture of weaning

foods, steered mainly by the Inter-Ministerial Drought Committee, in collaboration with the World Food Programme (WFP) and the United States Agency for International Development (USAID). UNICEF is mainly supporting health education to promote the use of household food from the "family pot", with an emphasis on the frequency of feeding and the addition of energy-dense nutrients to the young child's diet. There is a need to protect and, if possible, increase present levels. Maternal work-load may also have a negative effect on breast-feeding, but there is insufficient data on this subject. Studies on maternal work-load and its effect on child feeding are planned under the household food and economic security component of the proposed programme.

Control of diarrhoeal diseases

14. A 1986 study of diarrhoea suggested that the number of diarrhoeal episodes for children under one year of age was 4.5 per year, and 3.8 per year for children under five years old - rates as high, if not higher, as in other African countries. The overall mortality rate, however, was quite low (10.8 per 1,000 live births). This was largely a result of the effective treatment of diarrhoea through the extensive use of oral rehydration therapy (ORT), which was estimated in 1986 at 67 per cent for children under one year of age and 64 per cent for children under five years old. The greatest problem now is how to promote the boiling of drinking water, given the acute shortage of fuel wood. Future efforts will also concentrate on improving the percentage of households with improved pit latrines. An ORT training centre was established at the end of 1988. By the end of July 1989, all health regions had trained trainers in the expanded programme on immunization (EPI) and the control of diarrhoeal diseases (CDD).

Self-help rural sanitation

15. The self-help rural sanitation project, funded by the Government with support from UNICEF, the United Nations Development Programme (UNDP) and the World Bank, had the primary objective of assisting households in four districts to build and use well-constructed, ventilated improved pit latrines (3,145 units) and to help the Government to formulate a rural sanitation policy and operational strategies. A 1988 evaluation recommended that since project objectives had been successfully achieved it would now be appropriate to expand the effort into a national rural sanitation programme. To facilitate this expansion, it was agreed that a preparatory phase should first be undertaken (1989/1990-1990/1991), with the support of the Swedish International Development Authority (SIDA), to develop a coherent national programme as part of the Seventh National Development Plan (1991-1996). In the meantime, full implementation of the project continues in eight districts. The preparatory phase will develop a rural sanitation sector strategy, undertake a knowledge, attitude and practice (KAP) survey and a cost analysis study and design a health impact study, as well as complete outstanding research and development projects. At the end of this phase, a project document will be prepared for submission to the 1991 UNICEF Executive Board for supplementary funding.

Acute respiratory infections

16. The programme for the control of acute respiratory infections (ARI) was launched in late 1988. The priority concerns are to develop national ARI control and management guidelines; to review the health management information system to make ARI information more useful and accessible for programme management; to streamline the essential drugs policy in order to facilitate the decentralization of ARI case management at the community level; and to strengthen health education and social mobilization for ARI prevention.

Training of village health workers

17. Much attention has been focused on the role and activities of village-level health workers, especially on the training of family welfare educators. Their role originally reflected an emphasis on community outreach, but over the years the staffing needs of the rapidly expanding rural health infrastructure and the inclination of the family welfare educators themselves have led them to become largely facility-based. In addition, the use of health facilities for the distribution of drought relief food necessitated their use at the clinic level to cope with the additional work. The training programme itself is well operated, but the number of trainees has fallen well short of target. Of central importance in this regard is a government policy statement that family welfare educators should be more community-based and should be given the incentives and tools to carry out their new roles adequately. The remaining challenge is to effectively organize and implement a truly community-based health worker programme managed by local communities themselves. Pilot activities will be undertaken in Ghanzi and Lobatse during the proposed country programme.

Education

18. Botswana has undertaken a major curriculum reform programme designed to provide basic education for the first seven years of primary schooling. The emphasis is on "Education for Life" and the programme focuses on basic skills. In the context of this curriculum reform, UNICEF has supported the review of the science curriculum in order to enhance the relevance and quality of health, nutrition and child development in primary schools.

19. The National Literacy Programme, begun in 1980, has reached over 170,000 individuals. UNICEF has supported literacy activities through the development and production of booklets and pamphlets on CSD concerns for use by neo-literates; the retraining of non-formal education extension workers in CSD issues, including writers' workshops; functional skills training for beginning income-generating projects; the reorientation and strengthening of the Home Economics Programme of the Department of Non-Formal Education so as to increase its effectiveness; and strengthening of field supervision in remote locations. Considerable attention is being given to the possibility of literacy groups' engaging in income-generating activities. In 1989, the Department of Non-Formal Education initiated a study on implementation strategies for a post-literacy phase for the Home Economics Programme. The Department is also designing a study to reorient its activities towards post-literacy. Attention will now be focused on linking literacy with post-literacy productive employment, especially for women and young girls.

Other programmes

20. UNICEF supported a 1988 childhood disability detection and prevention survey and drew attention to the need to raise the awareness of primary school teachers, family welfare educators and other health workers of the special education needs of disabled children. The importance of strengthening the school health programme was also underlined by a 1988 workshop. During the period under review, the Ministry of Health appointed an officer based in the Maternal and Child Health/Family Planning Unit to co-ordinate school health.

21. Day-care services reached approximately 7,000 children, or barely 3 per cent of all children in that age group. UNICEF has supported basic training for day-care teachers, in-service training of day-care supervisors and owners, parents' education and infrastructure development for the Lobatse Day-Care Teacher Training Centre and the Selebi-Phikwe Day-Care Centre. A 1988 evaluation undertaken by the Social and Community Development Division of the Ministry of Local Government and Lands, with UNICEF support, recommended the streamlining of administrative and technical responsibilities for day-care and the development of operational guidelines. These recommendations have been taken into consideration in the preparation of the proposed country programme.

22. UNICEF has supported the strengthening of data collection, analysis and dissemination in order to facilitate CSD programme planning and implementation. The period under review has seen increased concern for the reorganization of the health information management system. A task force has been formed to review the existing instruments and make information collection easier and more amenable to interpretation.

RECOMMENDED PROGRAMME CO-OPERATION, 1990-1994

Recommended general resources: $2,500,000
Supplementary funding: $5,183,000

Recommended programme co-operation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health			
Immunization	160	647	807
Control of diarrhoeal diseases	45	127	172
Other health	795	909	1 704
Subtotal	1 000	1 683	2 683

/...

	General resources	Supplementary funds b/	Total
Household food security	500	2 000	2 500
Education	370	981	1 351
Young child development	130	519	649
Programme support	500	-	500
Total	2 500	5 183	7 683

a/ The breakdown for estimated yearly expenditures is given in table 2.

b/ In addition, there are also approved and supplementary funding projects shown in table 2.

23. The proposed programme has been developed under the auspices of the joint Government of Botswana/UNICEF Programme Planning and Co-ordinating Committee. As part of this process, a study of the situation of children and women was undertaken.

24. The programme preparation process was a highly participatory exercise, involving government ministries (Finance and Development Planning, Health, Education, Local Government and Lands, Agriculture, Labour and Home Affairs, Commerce and Industries), bilateral and multilateral development agencies (USAID, SIDA, the Norwegian Agency for International Development (NORAD), the Canadian International Development Agency, the European Economic Community (EEC), UNDP, the World Health Organization (WHO), WFP and the United Nations Population Fund (UNFPA) and local and international organizations (the International Committee of the Red Cross (ICRC), the Child-to-Child Foundation, the Botswana Council of Women, the Young Men's Christian Association (YMCA), the Girl Guides Association, Thusano Lefatsheng, the Brigades Co-ordinating Committee, the Netherlands Development Organisation, etc.). The programme was formulated by four task forces appointed by the Government to cover the following spheres of activity: PHC; basic education; household food and economic security; and social mobilization. The active involvement of these task forces, as well as of members of the joint Goverment/UNICEF Programme Planning and Co-ordinating Committee and senior officials from all the sectoral ministries and the Ministry of Finance and Development Planning, was instrumental in ensuring a successful outcome.

25. The overall goals of the proposed programme are to reduce infant, child and maternal mortality in the context of the establishment of a decentralized and self-sufficient PHC system. It builds on the activities and achievements of the past programme, with some additions to meet emerging needs and seize new opportunities. Consistent with government policy, the programme does not seek to create new structures, but rather focuses on the optimal use of existing structures and services with any modifications that may be required.

Programme strategy

26. The programme design is based on an analysis of present opportunities and constraints. The opportunities include the demonstrated commitment and capacity of the Government to implement nation-wide programmes for disadvantaged groups. This capacity is best expressed through the impressive drought relief programme, the successful management of the economy, the expansion in social infrastructure and the accompanying beneficial impact on social indicators such as nutrition, mortality and morbidity rates and school enrolment. Some of the principal constraints include the shortage of trained personnel, possible shortfalls in recurrent budgets in the mid-1990s and the weak local capacity for self-managed service delivery and economic activities. Priority will be given to overcoming the principal constraints to decentralized planning and management. Key activities will include staff training, improvement in budgeting and disbursement procedures, mechanisms for planning at district and community levels and reinforcement of linkages between all key sectors.

27. The programme strategy calls for technical strengthening of the implementing agencies at the district level and the strengthening of village institutes through improved communication and social mobilization. Education will have to be more closely linked with post-education training opportunities which, in turn, should be more closely linked with the character of the emergent Botswana economy. Provision for health care will need to be more community-based, the quality of health care service provision will have to be improved, sustainability must be ensured and end-users must share a portion of the costs.

District planning and management

28. A major emphasis of the proposed programme strategy is the strengthening of district planning and management capacities with particular reference to PHC, basic education and household food and economic security. The present national concern is not drought (although it must never be forgotten that drought is cyclical and will recur), but rather the creation of employment, income, household food security and the reduction of poverty. Fortunately, the structures that were created or built up during the drought period have established communication channels and dialogue between macro-economists, sectoral planners and technical specialists in areas such as health, nutrition, agriculture, commerce and logistics.

29. Especially in the area of health, the planning of the proposed programme is based on a dynamic analysis of district capacity so that the implementation implications are directly related to the cumulative work-load of district services. The work-load required to maintain the performance levels of earlier programmes makes it impossible to undertake additional activities without risking a deterioration in the quality of overall performance. To minimize this overload, the integration of PHC activities at the district level must be strengthened and management must be improved. In this perspective, the PHC programme will be implemented in close co-ordination with the project of the Ministries of Health and Local Government and Lands for the improvement of district management of health services.

Community involvement

30. Another key element of the programme strategy is community participation and the strengthening of community institutions. This aspect is particularly important as attendance at rural health centres has decreased since the centres are no longer used as distribution points for relief supplies. Some of the most needy have stopped attending, but ways of reaching them must be found if high coverage is to be maintained and the achievements in nutrition, morbidity and mortality reduction are to be continued. More important, sustainable progress towards children's well-being requires the full and active involvement of the community. This is a particularly complex issue, however. Although communities have, in general, responded favourably in specific areas such as immunization, much needs to be done to strengthen village institutions to ensure their sustained involvement in the management of local development. Success in this area ultimately depends on the degree to which the new institutions draw strength from existing community organizations. It is important that women and youth find expression in these community institutions.

Social mobilization

31. The rapid rise in school enrolment and literacy, the training of an ever-increasing number of community health workers, the new and potential outreach of the print and electronic mass media, the upsurge of voluntary and religious work at the community level, the decentralized government structure and the growing outreach of extension services have all made it possible to support the vast majority of parents and administrative authorities in using today's scientific knowledge to protect the lives and growth of all the country's children. Social mobilization is not new to Botswana, having been a central feature of tribal administration. Acknowledged by the extension service, which started in 1914, it has been used more recently for the specific objectives of combating drought and achieving UCI, and is a major feature of the current reorientation of rural development policy led by the Rural Development Council. The challenge in the coming five years will be to mobilize all those resources behind the common objective of reducing infant and child mortality and malnutrition so that each may play a part in keeping the country's children alive and able to develop fully. This is part of the thrust for overall health promotion proposed for inclusion in the Seventh National Development Plan (1991/1992-1996/1997).

32. The proposed programme has been drawn up on the basis of gender-responsive planning which recognizes the important roles that every member of society - both males and females at all social levels - has and will continue to play in ensuring CSD. Now that drought relief measures have ended, new approaches need to be found to keep mortality and malnutrition down (or indeed, reduce them further) in a way that can be implemented and sustained by parents and communities themselves and that does not require the kind of extraordinary measures necessitated by the peculiar circumstances of the drought.

Human resource development

33. The ministries of Health and Local Government and Lands are currently implementing a district management improvement project. Three separate management analysis studies have already been conducted regarding the personnel, supervision and communication systems supporting PHC in a sample of district and town councils. One of the major findings is that the National Health Institute, which is the main in-country training institute for health workers, is not producing enough personnel to satisfy national needs, particularly in the case of post-basic training. This supports the widely held view that the lack of adequately trained staff is perhaps the major constraint to development in the 1990s. Consequently, the proposed programme attaches high priority to training and human resource development, especially with regard to district-level needs. Links are, therefore, being intensified with relevant national and regional training institutions, notably the National Health Institute, the Institute of Development Management and the Eastern and Southern African Management Institute.

Primary health care

34. To accelerate the achievement of PHC goals and objectives, the Government plans to strengthen the integration of PHC at the district level. Increased utilization of health services will be promoted through strengthened community involvement and participation. Health service delivery will be further decentralized through the strengthening of local authorities in the effective management, planning and implementation of programmes and in the provision of appropriate logistical support. The mobilization of intersectoral participation at the district level and staff training will also be emphasized in order to ensure qualitative improvements in service delivery. Close collaboration will also be maintained with donor agencies and NGOs to ensure complementarity and the standardized application of new norms and procedures.

35. UNICEF support to existing activities will be maintained, with the addition of some new areas that are significant to CSD and the promotion of women's health. The main areas of support will be EPI, CDD, the control and case management of ARI, malaria control, safe motherhood, perinatal health promotion and human resource development. Social mobilization is an integral component of each programme activity.

Expanded programme on immunization

36. Botswana achieved UCI in December 1988, so the main goals are now to ensure its sustainability and to eliminate neonatal tetanus and polio through the following activities: in-service training of PHC workers in order to improve the quality of services; increasing social mobilization efforts to raise and sustain demand for immunization services; strengthening of district-level capacity for programme planning, management and co-operation; and provision of vaccines, cold-chain supplies and equipment. Special efforts will be made to improve management and monitoring by improving the health management information system.

Control of diarrhoeal diseases

37. Diarrhoeal diseases remain a major cause of childhood morbidity, with an average of 3.8 episodes of diarrhoea for each child under five years of age. The goals of the CDD programme are to reduce diarrhoea-related mortality by 30 per cent by 1995, to increase access to oral rehydration salts (ORS) to 100 per cent and ORS utilization to 80 per cent. These goals will be accomplished through the strengthening of the programme planning and management capacity of the EPI/CDD unit for routine surveillance so as to ensure timely intervention. Efforts will be made to increase and sustain demand for ORS and to promote improved sanitation, personal hygiene, breast-feeding and improved weaning practices. PHC workers will continue to receive in-service training in order to improve service delivery. In order to ensure sustainability, the Government will assume the recurrent costs of EPI and CDD programmes at both national and district levels.

Acute respiratory infections

38. ARI is the most common diagnosis made at health posts and represent 35 per cent of all diagnoses in all age groups and 43 per cent of all diagnoses in children under five years of age. In addition, ARI is the second major cause of death in children under five years old (11.2 per cent in 1984) after perinatal deaths. The objectives, which are to reduce the case fatality rate by 25 per cent by 1995 and to improve the control and clinical management of ARI, will be achieved through improved programme management, the referral of children with ARI, the training of PHC workers and community education about the causes, methods of prevention and control of ARI. ARI will be closely monitored to determine programme impact. In this regard, efforts are under way to review the instruments for notification of diseases in order to include ARI. Programme implementation will have to be accelerated if a significant impact is to be made within the programming cycle.

Malaria control

39. The transmission of malaria in Botswana is seasonal, resulting in low immunity in the general population since the antigen stimulation is not sustained throughout the year. As a result, malaria morbidity was relatively low during the drought years (1981-1986), thereby reducing malaria deaths in children and further contributing to the lowering of IMR and U5MR. The objectives of the malaria control programme, therefore, are to reduce malaria morbidity by 30 per cent and case fatality by 80 per cent by 1995. This will be accomplished through the training of PHC workers to ensure improved malaria prevention and case management, community education about malaria prevention and control, operational research to strengthen the management and prevention of malaria, and improved monitoring of malaria morbidity and mortality to ensure that prompt action is taken at times of epidemics and to assess chloroquine and other drug resistance.

Safe motherhood

40. Although at least 77 per cent of normal deliveries are assisted by trained health workers, maternal mortality remains at around 200 per 100,000 live births. At least 70 per cent of these deaths could be avoided. About 47 per cent of maternal deaths occur in high-risk women, including teen-age mothers. The incidence of teen-age pregnancy in the country is high; approximately 25 per cent of girls between 15 and 19 years of age have at least one child. In addition, little is known of the perinatal indicators, and the advent of acquired immunodeficiency syndrome (AIDS) is likely to increase greatly the number of child and maternal deaths unless swift and consistent action is taken. The objectives of the project are to reduce significantly the transmission of the human immunodeficiency virus (HIV) and the incidence of AIDS, to increase the proportion of women attending antenatal clinics, to increase the proportion of supervised deliveries to 90 per cent, to promote the reduction of teen-age pregnancy to less than 15 per cent and to reduce the perinatal mortality rate by 20 per cent by 1995. This will be achieved through information and social mobilization to promote safe motherhood and increased in-service health worker training to ensure improved risk-factor screening. Reviews of monitoring instruments to sharpen the focus on maternal health status indicators will be undertaken and improvements will be made.

Health manpower development

41. There is a shortage of most categories of staff as well as a lack of career development incentives and opportunities. The basic training curriculum needs to be restructured to meet the development needs of the health system. The objective of the project is to update the knowledge and skills of PHC workers in order to improve the quality of health care delivery. This will be accomplished through the provision of technical support, the reorientation of PHC staff trainers and mid-level managers, the review and expansion of the training curricula of health workers and training to strengthen project management.

Basic education

42. This programme, in three substantive projects, will address qualitative problems associated with the expansion of the system to ensure democratization of education for all. The particular groups of concern are young children two to six years of age, children within the school system in the first nine years and children and adults outside the system who may acquire a basic education through the National Literacy Programme. The programme is also concerned with broad socio-economic development issues. Basic education is defined in broad terms as the acquisition of relevant knowledge, skills, attitudes and values and as an essential element of every attempt to improve and develop the human condition. Education is thus regarded as essential to health, nutrition, income generation and environmental protection. It is equally important for the inculcation of self-reliance, initiative, intellectual curiosity and adaptability. The programme is designed to contribute to the empowerment of individuals and communities through the transfer of knowledge and information by the promotion of positive attitudes to learning and the application of knowledge and skills.

43. The project on the care and education of the young child responds to the needs and rights of children from two to six years of age in the changing social and demographic circumstances of Botswana. Public demand for day care has increased as a result of a growing awareness of the benefits of early socialization and intellectual stimulation for the young child. Demand has been further stimulated by the impact of urbanization on traditional patterns of child care, the increased number of one-parent families headed by working mothers and the enrolment in primary school of older siblings who would otherwise have cared for the younger children. Improved provision of day care is seen as part of a strategy to improve the health and nutritional status of young children. Day care is also seen as a means of achieving social equity and ensuring equal opportunity in the education system. The project aims to facilitate rationalization of the day-care programme and to support the revision of operational guidelines and day-care curricula to ensure learning opportunities and foster socialization and sustained development through activity, discovery, play and acceptable habit formation. Trainers, supervisors, curriculum developers and day-care attendants will have to be trained accordingly, and appropriate learning materials will have to be designed and promoted. Efforts will also be increased to create an informed public and to motivate community involvement in early childhood care and development.

44. The long-term goal of the basic formal education programme is to provide nine years of basic education for all children. Substantial progress has already been made, as 85 per cent of the primary school age group are currently enroled in a seven-year cycle, and some 58 per cent of them proceed to junior secondary school. It is intended that by 1995, when the primary and junior secondary cycles will become one basic education cycle of nine years, the transition from primary to junior secondary will have reached 100 per cent. The challenge, however, is to design a basic education curriculum that is relevant to various needs in different locations, is adaptable to changing circumstances and inculcates the attitudes, skills and values that will make the individual a useful and productive member of the community. The objective of the project is, therefore, to introduce learning content relevant to different localities and individual learners into the basic education core curriculum. That content must be presented so as to promote self-learning, self-reliance and initiative and must also be practical preparation for a productive life.

45. Technical support will be provided and national technicians will make study visits to observe alternatives and work done in other countries. Teacher education will be an important part of the programme, along with regional surveys, research and needs analyses. Social mobilization support will be provided to sensitize educational personnel, parents, students and the general public about the rationale for curriculum reform and the value of the innovations.

46. The objectives of the proposed non-formal education project are to extend the coverage of the National Literacy Programme to remote areas and to develop increasingly functional approaches to school drop-outs and post-literates, especially women and girls. This will include not only "the three R's" (reading, writing and arithmetic) and other communication skills, but also basic functional and enterpreneurial skills for self-employment. Through social mobilization activities, neo-literates will be provided with information regarding their status

and rights, acquire knowledge on health, nutrition and sanitation and be encouraged to participate in income-generating groups and activities. Continuous programme monitoring will be facilitated through the appointment of a research and evaluation officer within the Department of Non-Formal Education.

Household food and economic security

47. This programme builds upon the solid base of drought management experiences and signals a qualitative change in the Government/UNICEF programme of co-operation in that it supports efforts to tackle the significant structural poverty that disproportionately affects women and children. The proposed programme will involve participation and a research programme to support efforts at the national level, and in a few selected districts and localities it will promote wider implementation of appropriate techniques and strategies for achieving more self-reliant, sustainable and drought-proof local community development.

48. The Government has already established an infrastructure and a number of projects, programmes and facilities to provide inputs and services for employment and income generation. Several NGOs are also active, but with localized impact. In order to improve the targeting of government services and expand the impact of innovation by NGOs, the following broad strategy elements are proposed:

(a) Strengthening district- and community-level management of available development resources to improve service delivery for household income and food security;

(b) Improving the targeting of resources and service delivery to the most vulnerable individuals, households and groups in Botswana;

(c) Promoting both maternal and child survival and development (CSD) as key indicators of improved household income and food security.

49. The programme goal is to improve household food and income security, with a special focus on ensuring access and control of resources in the most vulnerable households, especially female-headed households in the poorest communities.

50. UNICEF support will be organized and mobilized through existing governmental and non-governmental structures and services. The main policy objective is to improve information systems and the data base by improving the nutrition surveillance system, strengthening the analysis of causal factors of malnutrition and refining indicators to facilitate the updating and implementation of the National Food Strategy. This would also help to identify specific action proposals.

51. Institutional capacity-building at the district level would consist mainly of training and technical support for district level staff (mostly women) to manage the nutrition surveillance system. The data generated would serve as a basis for district planning and the targeting of interventions.

52. Direct interventions will, in some cases, include direct financial and technical support for activities that would enhance household food security of the poorest: food production, processing and storage or other income-generating activities. They will also include institutional strengthening of grass-roots organizations such as district extension teams, village development committees, NGOs and women's groups to promote those activities. The exact formula for supporting direct interventions would be agreed upon by the Project Management Committee and an ad hoc intersectoral group working under the Rural Development Co-ordinating Unit at the end of the programme's first year, in the light of the results of the activities to be implemented under the projects described above.

53. Projects will be monitored through the strengthening of established routine monitoring systems at national and district levels. Project evaluations will be conducted periodically in accordance with programme plans. Monitoring of the proposed country programme as a whole will be overseen by the joint Government/UNICEF Programme Planning and Co-ordinating Committee through quarterly progress review meetings, as well as through the annual review exercise. During the progress review meetings, each department or agency responsible for implementing various programme activities will submit quarterly and/or annual progress reports to the Committee detailing planned activities and targets, objectives, progress made, constraints and planned solutions, in addition to plans for the next quarter or year. There will be a comprehensive mid-term review in 1992. The Committee has been an excellent intersectoral forum for dialogue on CSD concerns. Committee membership has remained stable, thus ensuring the existence of an important nucleus of key government officials with a wealth of knowledge and commitment to CSD concerns.

Co-operation with United Nations agencies and other organizations

54. In PHC, UNICEF works with NORAD (logistics support for vaccines and pharmaceutical products), USAID and UNFPA (safe motherhood), WHO, the World Bank and the African Development Bank (AfDB), to name only a few. In basic education, there is strong co-operation with SIDA (primary education and adult literacy), USAID (primary and junior secondary schools), UNDP and the United Nations Educational, Scientific and Cultural Organization (UNESCO). In the area of household food and economic security, UNICEF collaborates with EEC, USAID and WFP, among others.

Financial resources

55. The proposed programme will require an increased level of funding from both the Government and UNICEF in order to continue successfully ongoing programme components and permit the introduction of additional components. The Government's commitment to improving the situation of women and children is reflected in the significant increases in the basic services budget allocation that are expected to continue in the Seventh National Development Plan (1991-1996). In the proposed programme, the Government will cover all recurrent expenditures. UNICEF will provide technical support, supplies and equipment, while the Government will assume responsibility for an increasing proportion of the components carried over from the

previous programme. The Government will thus take over responsibility for the provision of ORS in April 1990 and the provision of all vaccines (except polio, which is provided by Rotary International) and cold-chain supplies and equipment, beginning in April 1991.

BOTSWANA

Basic data: 1988 and earlier years

Under-five mortality rate	92	(1988)
Infant mortality rate	66	(1988)
GNP per capita	$1,050	(1987)
Total population	1 million	(1988)

UNICEF country classification

Middle U5MR
Middle IMR
Lower-middle GNP

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1988
Births	(thousands)	34	45	52	57
Infant deaths (under 1)	(thousands)	3	4	4	4
Under-five deaths	(thousands)	5	5	5	5
Under-five mortality rate (per 1,000 live births)		143	110	100	92
Infant mortality rate (under 1) (per 1,000 live births)		102	79	71	66

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1987)	Moderate & severe	..	15
	Severe	..	..
Babies with low birth weight (%, 1986)		..	8*
Children completing primary level (% of first grade, 1986)		..	89

NUTRITION INDICATORS		About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1984)		../../..	96/93/73
Prevalence of wasting (%, 1980/1986)		19	6*
Prevalence of stunting (%, 1980/1986)		51	25*
Daily per capita calorie supply (% of requirements, 1979-1981/1984-1986)		93	96
Food production per capita index (Index 1979-1981=100, 1980/1987)		88	75
Household expenditure (% of total income, 1980-1985)	All food/cereals		35/13

HEALTH INDICATORS		About 1980	Most recent
ORS use rate (%, 1986-1987)			35
Access to health services (% of population, 1980)	Total	89*	..
	Urban/rural	100*/85*	../..
Access to safe water (% of population, 1986)	Total		54
	Urban/rural	.. /..	84/46
Access to adequate sanitation (% of population, 1986)	Total		42
	Urban/rural	.. /..	93/28
Births attended by trained personnel (%, 1988)		..	77
Maternal mortality rate (per 100,000 live births, 1980)		250	..

Immunization		1981	1985	1987	1988
One-year-olds (%) immunized against:	Tuberculosis	80	68	99	99
	DPT	64	68	86	89
	Polio	71	67	88	89
	Measles	68	68	91	83
Pregnant women (%) immunized against	Tetanus	32	17	40	61

BOTSWANA

Basic data: 1988 and earlier years			UNICEF country classification
Under-five mortality rate	92	(1988)	Middle U5MR
Infant mortality rate	66	(1988)	Middle IMR
GNP per capita	$1,050	(1987)	Lower-middle GNP

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net)	Total	91/75	114/89
(%, 1980/1987)	Male	82/68	111/85
	Female	100/82	117/93
Secondary enrolment ratio (gross/net)	Total	19/15	32/26*
(%, 1980/1987)	Male	18/12	31/26*
	Female	21/17	33/26*
Adult literacy rate, 15 years & older	Total	41	71
(%, 1970/1985)	Male/female	37/44	73/69
Radio/television sets			
(per 1,000 population, 1980/1987)		../..	130/ 7

DEMOGRAPHIC INDICATORS		1970	1980	1985	1988	2000**
Total population	(millions)	0.6	0.9	1.1	1.2	1.8
Population aged 0-15 years	(millions)	..	0.4	0.5	0.6	0.9
Population aged 0-4 years	(millions)	..	0.2	0.2	0.2	0.3
Urban population (% of total)		8	15	19	22	33
Life expectancy at births (years)	Total	59	63	64	64	68
	Male/female	49/52	52/58	54/60	56/62	62/67
Total fertility rate		6.9	6.6	6.4	6.2	5.3
Crude birth rate (per 1,000 population)		53	50	48	47	40
Crude death rate (per 1,000 population)		17	15	13	11	7

		About 1980	Most recent
Contraceptive prevalence rate		..	28
(%, 1984)			
Population annual growth rate	Total	3.5	3.6
(%, 1965-1980/1980-1987)	Urban	15.4	8.2

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate		9.9	8.0
(%, 1965-1980/1980-1987)			
Inflation rate (%, 1965-1980/1980-1987)		8	8
Population in absolute poverty	Urban/rural	40/55	../..
(%, 1980)			
Household income share	Top 20%/bottom 40%	../..	../..
(%)			
Government expenditure	Health/education	6/10	6/18
(% of total expenditure, 1972/1987)	Defence	(.)	8
Household expenditure	Health/education	4/ 9	../..
(% of total income, 1980-1985)			
Official development assistance:	US$ millions	106	154
(1980/1987)	As % of GNP	13	10
Debt service			
(% of goods & services exports, 1970/1987)		1	4

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

TABLE 1. BREAKDOWN OF ACTUAL EXPENDITURE FOR GENERAL RESOURCES AND SUPPLEMENTARY FUNDING UNDER PREVIOUS CO-OPERATION PERIOD, 1987-1989

(Thousands of United States dollars)

COUNTRY: BOTSWANA
LATEST BOARD APPROVAL: 1987
GENERAL RESOURCES: $1,285,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	SF	GR	SF	GR	SF	GR	SF	GR	SF	Total
Health	444	187	12	50		307	25	559	482	1103	1585
Water supply and sanitation		202						56		258	258
Nutrition	43						22		65		65
Education	15		5				8		28		28
Community organization and development	16	11		78			7	36	23	125	148
Young child development							7		7		7
Women-centred programme	22						20		42		42
Emergency	3	42							3	42	45
Planning and project support	34		3		154	7	97	1	288	8	296
Freight	72	50							72	50	122
GRAND TOTAL	649	492	20	128	154	314	186	652	1010	1586	2596

GR = General resources.
SF = Supplementary funding.

TABLE 2. PLANNED EXPENDITURE FOR GENERAL RESOURCES, NEW SUPPLEMENTARY FUNDING AND FUNDED SUPPLEMENTARY FUNDING

(Thousands of United States dollars)

Country: BOTSWANA Period covered: 1990-1994	Funding status	1990	1991	1992	1993	1994	Total
Health							
Immunization	GR	110	15	10	15	10	160
	FSF	274	43				317
	NSF		127	170	185	165	647
Control of diarrhoeal diseases	GR	10	10	5	10	10	45
	NSF	30	13	13	27	45	127
Other health	GR	80	175	185	175	180	795
	NSF	116	198	218	188	190	909
Subtotal, health	GR	200	200	200	200	200	1000
	FSF	274	43				317
	NSF	146	337	400	400	400	1683
Household food security	GR	100	100	100	100	100	500
	NSF	520	422	454	303	302	2000
Education	GR	100	102	61	61	46	370
	NSF	134	186	212	217	232	981
Young child development	GR	30	31	29	20	20	130
	NSF	64	108	113	99	135	519
Planning and project support	GR	100	100	100	100	100	500
TOTAL	GR	530	533	490	481	466	2500
	FSF	274	43				317
	NSF	864	1053	1179	1019	1069	5183
GRAND TOTAL		1669	1629	1669	1500	1535	8000

GR = General resources.
NSF = New supplementary funding.
FSF = Funded supplementary funding.

/...

TABLE 3. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: BOTSWANA	Number of posts	1990-1991 amount (Thousands of US dollars)
FINANCED FROM 1990-1991 APPROVED BUDGET:		
International Professional established posts	1	145
Local national Professional and General Service established posts	4	147
Operating costs		297
Total	5	589
FINANCED FROM PROGRAMME FUNDS: a/		
International Professional project posts		
General resources	1	135
Supplementary funds	2	300
Local national Professional and General Service project posts		
General resources	2	78
Supplementary funds	2	72
Total	7	585

a/ For information source, see 1990 post authorization table, revised October 1989.

Annex

SELECTED LIST OF STUDIES AND EVALUATIONS

1. Botswana national EPI evaluation, September 1987.

2. Evaluation of the Botswana growth monitoring and promotion programme, November 1987.

3. Evaluation of the Botswana national nutrition surveillance programme, August 1988.

4. Summative evaluation of the Botswana self-help rural sanitation project, November 1988.

5. Summative evaluation of the Botswana day-care programme, January 1989.

6. Botswana radio listenership study, June 1988.

7. Children, women and development in Botswana: a situation analysis, October 1989.

8. Review of the 1987-1989 Government of Botswana/UNICEF programme of co-operation, October 1989.

UNITED
NATIONS

E

Economic and Social Council

Distr.
LIMITED

E/ICEF/1990/P/L.3
22 March 1990
ENGLISH
ORIGINAL: ENGLISH/FRENCH

UNITED NATIONS CHILDREN'S FUND
Programme Committee
1990 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Comoros

The Executive Director recommends that the Executive Board approve a commitment of $1,500,000 from general resources, subject to the availability of funds, and an amount of $3,570,000 in supplementary funds, subject to the availability of specific-purpose contributions, for the country programme of the Comoros for the period 1990-1994.

* In order to meet documentation deadlines, this document was prepared before aggregate financial data were finalized. Final adjustments, taking into account balances of unspent commitments at the end of 1989, will be contained in the summary of 1990 recommendations for general resources and supplementary funding programmes (E/ICEF/1990/P/L.1).

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SITUATION OF CHILDREN AND WOMEN

1. The Comorian archipelago, situated at the northern entrance to the Mozambique Channel, between the east coast of Africa and Madagascar, is classified as a least developed country. The country's per capita income is $370. Following steady economic growth from 1979 to 1984, over the past five years there has been a sharp fall in the gross domestic product (GDP), which decreased from 2.7 in 1985 to 0.9 in 1988. The current economic growth rate is far lower than the population growth rate, which is 3.3 per cent.

2. In 1989 the Comoros had an estimated population of 439,055, with women representing approximately 50 per cent of that figure; the population is also very young, since almost 18 per cent of the population is under 5 years of age and more than 45 per cent is under 15 years of age. Most of the population (73 per cent) lives in rural areas.

3. In the early 1980s the Government drew up an interim development plan for the period 1983-1986, only 50 per cent of which was actually implemented, owing, inter alia, to a deteriorating economic situation, a low absorptive capacity and heavy indebtedness. In 1986 the plan was extended, but some of the goals set were no longer relevant. The country's development is now chiefly characterized by short-term concerns, and priority is being given to planning. Various major constraints are being encountered in the development process:

(a) A balance of payments in deficit;

(b) A marked deterioration in the terms of trade;

(c) A worsening budget deficit;

(d) Growing external debt ($200 million);

(e) The suspension of many loan payments; and

(f) A permanent lag in the payment of public employees' wages and salaries.

This disturbing situation prompted the Comorian authorities to step up their negotiations with the International Monetary Fund and the World Bank with a view to establishing a structural adjustment programme.

4. Comorian agriculture provides employment and a livelihood for almost 85 per cent of the population and accounts for 35 per cent of GDP. Of a total area of approximately 1,700 square kilometres (excluding Mayotte), an approximate area of only 100,000 hectares is cultivable, half of which is set aside for perennials, mostly food crops. Forty-five per cent of the foodstuffs consumed, and 90 per cent of the rice (staple food) consumed, is imported. According to recent estimates, the rural population spends almost 80 per cent of its income on food. In recent years the Government has abandoned the concept of self-sufficiency and has instead adopted the principle of food security. An extensive study that is to serve as the basis for the formulation of an agricultural strategy for the 1990s is currently being conducted.

5. The health situation in the country is linked to the low level of economic resources, geoclimatic conditions and food habits. It is difficult to assess the situation since statistical data collection is neither standardized nor systematic.

6. The infant mortality rate (IMR) and the under-five mortality rate (U5MR) remain very high (79 per 1,000 and 129 per 1,000 live births, respectively). Malaria, respiratory infections, anaemia and intestinal infestations are some of the chief causes of mortality and morbidity. The frequency of premature births and the great number of newborn infants weighing 2.5 kilograms or less at birth reflect the precarious state of maternal health. Almost 70 per cent of women visit a prenatal clinic, but only 20 per cent give birth at a health station under medical supervision. Anaemia is frequent among pregnant women. In 1987 the estimated maternal mortality rate was approximately 317 per 100,000 live births.

7. The health system is divided into three levels: central, intermediate and peripheral. Over 80 per cent of the population can reach a health station within one hour on foot, and there is an average of one health station per 5,000 inhabitants. However, the rate of attendance at health stations remains low because: firstly, the stations do not have enough equipment and basic medical materials; secondly, the stations do not receive essential drugs regularly; and, lastly, the health personnel is neither adequately trained nor sufficiently motivated. There is a pronounced imbalance in the distribution of health personnel; over 60 per cent of the doctors and midwives practise on the island of Grande Comore, where the capital, Moroni, is located. Moreover, the planning and supervision of health activities are not satisfactory. The health information and education systems are undeveloped. The health-activities budget remains small and is chiefly used for paying wages and salaries.

8. Surveys conducted between 1979 and 1985 show the extent of protein-calorie deficiency, particularly among women and children. For example, a World Health Organization (WHO) survey indicated that approximately 10 per cent of children aged 6 to 36 months suffer from severe malnutrition (weight/age ratio) and 37 per cent suffer from moderate malnutrition. The chief causes of malnutrition, particularly in a number of areas on the island of Anjouan, are poverty, bad food habits, bad weaning practices, infectious diseases and closely spaced births. There is as yet no national nutrition policy. Moreover, the growth of small children is not monitored consistently and mothers are given little nutrition instruction.

9. Currently, 50 per cent of the age-group 7 to 12 years is enrolled in school. There is a discrepancy between the enrolment ratio of boys (66 per cent) and that of girls (52 per cent). Only 31 per cent of children enrolled in the first year complete the elementary cycle; the remainder leave school at various levels, over 50 per cent (mostly girls) without having achieved functional literacy. Children also frequently repeat an academic year; in 1988 38 per cent of the school population did so. Thirty-two per cent of teachers are qualified. Parent-teacher associations are an important channel for mobilizing communities so that they are actively involved in maintaining and running primary schools in some areas. However, school attendance is still low because: school supplies are expensive; children must stay at home in order to carry out domestic and agricultural tasks; and school no longer automatically "feeds into" either public or private sector jobs.

10. According to the 1980 census, the illiteracy rate in the Comoros is 47 per cent (54 per cent among girls). The rural population is also at a disadvantage, with a total illiteracy rate of 52 per cent, compared with 34 per cent in urban areas. Since 1987, 43 pilot literacy centres have been opened, with an enrolment of 1,500, including 50 per cent women.

11. There is no legislation on water supply and sanitation. Roughly 43 per cent of the population has access to a supply system, but over 50 per cent of such systems do not guarantee safe water. In Grande Comore virtually every family has a cistern, often open and unprotected, for collecting rain-water. In Anjouan and Moheli surface water is used, and it is consumed without any prior treatment (settling/filtration).

12. Almost 90 per cent of the population has no access to a sanitation system. Families use shallow, unprotected dry-pit latrines dug close to dwellings. Neither health centres nor schools have any sanitation facilities. Scabies and intestinal infestations are frequent, providing confirmation of the population's inadequate food hygiene and personal hygiene. Furthermore, there is no system of household-refuse removal anywhere in the Comoros, and little attention has been paid as yet to environmental health. A sanitary engineering department was recently set up within the Ministry of Health, and the first class of sanitarians graduated from the National Health School in June 1989.

13. Surveys conducted in a number of villages have revealed the important role played by Comorian women in agriculture, particularly with regard to food-crop cultivation, in which 60 per cent of the work is done by women, who are becoming increasingly interested in market gardening. There are a number of obstacles, however, such as the burden of housework, inadequate financial resources, low education/literacy levels, lack of access to loans, the problem of preserving produce and the shortage of land.

PROGRAMME CO-OPERATION, 1987-1989

14. In 1987 the Executive Board approved programme co-operation for the period 1987-1991 in an amount of $2,600,000, including $800,000 from general resources and $1,800,000 in supplementary funds. In 1989 UNICEF intervention capacity in the Comoros was consolidated:

(a) The process of decentralizing the Antananarivo office to Moroni in the areas of programming, supplies and financial administration was begun;

(b) The number of staff was increased; and

(c) The annual general resources ceiling was raised from $160,000 to $300,000. The liaison office was upgraded to the level of sub-office. This recommendation is being submitted to the Board at its 1990 session because funds from general resources have been exhausted.

15. From 1987 to 1989 the country programme focused chiefly on two priority sectors: (a) health, with the relaunch of the expanded programme of immunization (EPI) in 1986; and (b) drinking water supply, a major concern of the Comorian Government.

Expanded programme of immunization

16. In the health sector, emphasis was placed chiefly on EPI, whose fundamental objective consisted, from 1986 onwards, in stepping up the campaign to achieve universal child immunization by 1990 and in consolidating what had been achieved so far. Since the relaunch of EPI, with the personal support of the President of the Republic, the Comoros has made a major effort and has thus achieved satisfactory results. A survey of immunization coverage of children aged 12 to 23 months conducted in September 1989 yielded the following results: 95 per cent in the case of tuberculosis vaccine; 78 per cent in the case of the third dose of oral vaccine against poliomyelitis; 82 per cent in the case of the third dose of triple vaccine against diphtheria, pertussis and tetanus; and 85 per cent in the case of measles vaccine. The survey was conducted with assistance from UNICEF and WHO. Tetanus immunization coverage is 59 per cent. Furthermore, 99 per cent of children have an immunization card. The series of efforts undertaken by the Comorian authorities, with support from WHO, the Canadian Public Health Association, the Rotary Club and UNICEF, has thus yielded results. An extensive "EPI-acceleration" operation is under way, with the aim of attaining universal child immunization by 1990. EPI has now identified as priority target-groups children up to the age of 12 months, women of child-bearing age and school-age chidren (poliomyelitis/tetanus booster). It seems necessary, from now on, to integrate EPI into the primary health care (PHC) activities to be carried out at health stations and in the villages.

17. Despite these encouraging results, EPI is still encountering the following problems:

(a) Decreased motivation of health personnel;

(b) a certain amount of compartmentalization of immunization activities, resulting from the vertical nature of EPI;

(c) Inadequacy of health monitoring and education;

(d) Flaws in the health information system; and

(e) The fact that health structures are not regularly supplied with essential drugs.

A survey conducted by WHO in 1988 also revealed that "missed opportunities" to immunize women ranged from 39 to 95 per cent, depending on the health structures or mobile teams concerned. Since January 1989 the Ministry of Health has been urging health personel to immunize women when they visit prenatal and child-health clinics, or during regular immunization sessions.

18. UNICEF contributed to this programme by providing all vaccines and immunization/sterilization equipment and materials, and by strengthening the cold

chain. It also provided vehicles and fuel, assisted in the periodic retraining of health personnel, supported awareness-raising and mobilization campaigns, and participated in monitoring activities.

19. In 1989 UNICEF undertook a global assessment of EPI and its strategies and made recommendations forming the basis of the 1990-1994 health programme. This programme comprises:

(a) The need to prepare a health-development plan;

(b) Effective integration of EPI into other PHC activities at the district level, and maintenance of what has already been achieved;

(c) Establishment of an effective epidemiological surveillance and disease control system, in accordance with the relevant WHO resolutions and the UNICEF strategies for the 1990s; and

(d) Establishment of management machinery and an ongoing supervision/evaluation process based on social, epidemiological and administrative indicators.

It will also be necessary to consider setting up a permanent system for supplying essential drugs, in order to restore the population's confidence and make health delivery more effective.

Diarrhoeal disease control

20. In March 1988, a national survey financed by WHO and UNICEF revealed the following facts:

(a) Among children aged 0 to 5 years, the diarrhoea-related mortality rate was 17.2 per cent;

(b) The incidence of disease corresponded on the average to five episodes per child per year;

(c) Traditional solutions (coconut water and rice water) were used; and

(d) Lastly, 96.6 per cent of the mothers breast-fed their children.

21. The national programme for the control of diarrhoeal diseases (CDD) was drawn up by the Ministry of Health in collaboration with WHO in September 1988. It was officially adopted in April 1989. Since 1987, UNICEF intervention has been limited to the supply of 188,000 oral rehydration salt (ORS) sachets, distributed through all health stations throughout the country, to support the local production of the central pharmacy which had proved inadequate and where the packaging and storage conditions posed problems.

22. In addition, in 1988, 90 health workers were trained in social communication applied to various programmes, including the CDD programme. Lastly, two operational research projects should be initiated in the very near future; these

projects are an analysis of the chemical composition of coconut water, and a clinical survey of diarrhoeal diseases among children.

Growth monitoring

23. UNICEF has contributed to the production of approximately 75,000 growth cards on which are printed the vaccination schedule and the weight curve graph. However, the health personnel use these cards only for the expanded programme of immunization (EPI), since the children are weighed only sporadically. In 1990, therefore, efforts will be intensified to establish a mechanism for the routine monitoring of the growth of children under 36 months of age as part of the integrated primary health care (PHC) project; training and awareness-raising should play a cardinal role.

Maternal and child health

24. UNICEF has supported maternal and child health (MCH) activities by equipping 20 health centres and rural maternity clinics with MCH kits and participating in the reprinting of prenatal cards. An integrated programme of MCH activities will be defined at the district level for the period 1990-1994.

Malaria control

25. Malaria is hyperendemic to the Comoros and is the primary cause of infant and child mortality and morbidity. It also has a great impact on the peri-natal mortality rate, the maternal mortality rate and the prematurity rate. UNICEF has co-operated with the United Nations Development Programme (UNDP) and WHO in malaria control by supplying materials designed to improve the quality of diagnoses and organize all the data collected during the many surveys carried out in the field.

Essential drugs

26. The lack of an adequate system for the regular supply of essential drugs is a serious obstacle to the proper functioning of the health services. A stock of basic drugs has thus been allocated to the outlying health posts, together with raw materials to enable the central pharmacy to resume the production of linctus, suppositories and aqueous solutions. The national authorities are encouraging the creation of village development committees, which are developing fairly rapidly, and the establishment of village pharmacies, as conceived under the Bamako Initiative.

Drinking water supplies

27. The provision of drinking water is a priority for the Comorian Government. Previously, UNICEF had limited its assistance to the construction of tanks to collect rain-water. In 1986, the Government devised a hydraulic project to supply drinking water to 17 villages in Grande Comore with a total population of 26,000. This project includes the construction of water supply points combining pipeline delivery and gravity-flow techniques, thus abandoning earlier experiments with hand and wind-driven pumps which were considered unsuitable.

28. Work on the first water supply project was completed at Foumbouni in 1988 after numerous setbacks: the absence of a national structure; the lack of skilled labour; insufficient awareness among recipient populations, which were supposed to contribute local materials and carry out some of the work; and the fact that the roles and responsibilities of each of the partners were not clear-cut. A co-ordination meeting provided an opportunity to evaluate this initial experience and draw from it any lessons that would be useful in pursuing the programme at the second site, N'Tsaouéni, for which part of the equipment and material has already been delivered. None the less, it is not possible to begin the works for lack of available supplementary funding. UNICEF has also contributed to the rehabilitation of 20 community cisterns in Grande Comore. From here on in, a health education and sanitation component is to be integrated into any drinking-water supply project.

The advancement of women

29. The project to promote the economic role of women focuses on food security within the family, income-generating activities for women and the improvement of women's knowledge of food/nutrition and techniques of processing and preserving products. Its implementation has been delayed owing to the reorganization of the Federation of Women's Associations, which, at the Government's request, is to assume chief responsibility. At this time, five recipient villages, with a total of 300 women, have been identified. The area study, which should help to pinpoint the concerns and needs of women more reliably, is to begin shortly. A pre-study questionnaire has been prepared. It deals mainly with the family situation, the assignment of chores, agricultural activities, the processing, preservation and marketing of products, sources of income and existing groups.

Social mobilization

30. In 1987, a consultant assisted the Government in developing a social mobilization strategy after identifying the country's resources and capacities in the area of information and communications. The following four components are the centre-piece of the proposed strategy:

(a) Mass information;

(b) Education of the public;

(c) Training of strategic partners; and

(d) Monitoring and evaluation.

An integrated approach must be taken.

31. A health education unit has been established at the Ministry of Health, and means of transport and audio-visual materials have been provided. In assessing needs, the unit discovered that the population does wish to participate in health development, that personnel in outlying areas are not sufficiently trained in communications techniques, and that it is important to have adapted teaching materials available.

32. In 1988, UNICEF provided support for the organization of the first National Health Week, whose activities included:

(a) The production of a video film;

(b) A song and drawing contest in the schools;

(c) Theatrical performances;

(d) The distribution of T-shirts and stickers; and

(e) The designing of billboards.

Structural adjustment with a human face

33. As a result of the awareness-raising process initiated by UNICEF, the Government has requested an analysis of any social consequences of the structural adjustment programme, even before negotiations lead to the signature of an agreement with the World Bank. UNICEF has seconded a consultant to the Government, who, on his first mission, identified the three target groups on which attention must be focused:

(a) Young people fresh out of school (between 6,000 and 8,000 young people enter the labour market every year);

(b) Civil servants who have been dismissed (each of whom is often responsible for providing for 12 to 15 people); and

(c) Rural women.

A second mission will be devoted to the elaboration of a social strategy to be introduced into the 1990-1992 public investment programme.

Lessons drawn from past co-operation

34. The programme has been implemented in a context of austerity. The chief constraints have been:

(a) The disturbing financial situation, as a result of which the authorities have not always been able to honour their commitments;

(b) The greatly reduced staff at the UNICEF office in Moroni;

(c) The poor monitoring of field activities;

(d) Inadequate mobilization of recipient communities, especially with regard to the water project; and

(e) The serious problems relating to communication with the outside world (telephone/telex/post).

Certain activities have had to be shelved - for example, growth monitoring and diarrhoeal disease control (CDD) - in the absence of a uniform national policy in the areas in question. These last two activities will be redefined in the context of 1990-1994 programme co-operation and be integrated into a primary health care (PHC) project in order to guard against any lack of focus or co-ordination in future initiatives.

RECOMMENDED PROGRAMME CO-OPERATION, 1990-1994

General resources: $1,500,000

Supplementary funding: $3,570,000

Recommended programme co-operation a/

(Thousands of United States dollars)

	General resources	Supplementary funding b/	Total
Health	587	943	1 530
Nutrition	86	-	86
Education	160	584	74
Drinking water supply/ sanitation	6	2 043	2 049
Programme support	661	-	661
Total	1 500	3 570	5 070

a/ A summary of estimated annual expenditures appears in table 2.

b/ Table 2 also includes projects from funded supplementary funding.

Preparation of the country programme

35. The overriding concern in the programming exercise was to ensure that national partners play a more active role at every stage. For the first time, the analysis of the situation of Comorian women and children was assigned to an exclusively Comorian team, whose work was co-ordinated by the General Directorate of the Ministry of Planning. Many multisectoral meetings and discussions were held with both the authorities concerned and technical experts from the ministries, in order to consider concerns and constraints in the country, frame objectives, formulate

strategies, and identify activities that should be strengthened or introduced. All donors active in the sectors covered by UNICEF were also included in this long process.

36. The future programme dovetails into the UNICEF medium-term plan for the period 1989-1992, into UNICEF's institutional priorities and into the strategies and objectives proposed for the 1990s. Prior experience and the absorptive capacity of both the Comorian Government and the UNICEF Office in Moroni have been taken into consideration. The concept of integration, grass-roots participation and the institutionalization of a regular monitoring and evaluation system, complete with indicators and inspection schedules, will be key elements of this programme.

Overall objectives

37. The aim of programme co-operation will be to support Government efforts to:

(a) Reduce significantly the infant mortality rate (IMR), the under-five mortality rate (U5MR) and the mortality rate among mothers;

(b) Ensure that women and children have a balanced diet;

(c) Promote basic education and improve the quality of teaching;

(d) Make the population aware of sanitation problems in their area and of environmental protection issues; and

(e) Encourage, more and more, active grass-roots participation in the development of the country.

General strategy

38. UNICEF collaboration to ensure the protection, survival and development of the Comorian child will be developed largely in the outlying areas. Financial resources will be allocated to priority components identified by the Government, in areas where it seems most likely that programme activities will have a real, tangible and continuing impact. Particular emphasis will be laid on the integration of activities that will contribute both to reducing mortality and morbidity among young Comorian children and their mothers and to improving the quality of the services provided to the most destitute rural populations on all three islands.

39. The 1990-1994 programme continues the efforts undertaken between 1987 and 1989, particularly in the sectors relating to health and drinking water supply, this time with emphasis on environmental sanitation. Some activities have been replanned, redefined and reorganized with a view to constituting a more coherent range of intervention. Activities relating to nutrition, staff training and nutrition education for mothers have been included in the programme for the first time. It is also the first time that a national survey is being conducted. Under the programme, UNICEF will resume its activities in the education sector, provide assistance in improving the quality of primary education and support training for

women based on literacy education. Women both as agents in and beneficiaries of the overall development process remain the focus of the whole range of activities selected.

40. All forms of action will receive extensive support from an information/education/communications component that will be an integral part of all projects and make use of local resources and skills from a variety of environments in order to guarantee the population's support and active involvement. The Facts for Life strategy will be implemented.

Health

41. The overall health objectives may be summarized as follows:

(a) To contribute to the reduction in infant, child and maternal morbidity;

(b) To increase the credibility of the health system in general by motivating health personnel and by improving the quality of the benefits provided to the population;

(c) To ensure that mothers use the health services regularly;

(d) To encourage the population to play an active part in the health development of the district; and

(e) To strengthen staff capacity to carry out monitoring and evaluation activities at both the central and the peripheral levels.

42. Health interventions will be mainly concentrated in an integrated project that will gradually cover 14 health districts, with a population of 331,652, including 13,263 infants of up to 12 months of age, 45,435 children from one to four years of age, 72,957 women of child-bearing age, and an average of 14,589 pregnant women. The districts must meet the following four key criteria:

(a) Presence of a head doctor to manage and provide ongoing supervision of activities and to provide leadership;

(b) Presence of two midwives who can take over from one another each month and visit the villages;

(c) Establishment of a village development committee and identification of an informant-liaison official for several villages of the district; and

(d) A population that has shown an interest in taking responsibility for its own health and that has already been introduced to a number of community activities.

The informant-liaison official is a member of the community chosen by both the community and the head doctor of the district, following consultation with the head of the village and the chairman of the village development committee. He plays an active role in screening for the target diseases in mothers and children, as well

as in the health education of the population, thus providing liaison with the village and the health personnel. He is given five days of training by the head doctor of the health district and is regularly supervised by him and the two district midwives. The health activities will be started up in the five districts in the first year and gradually be extended to the other districts at a rate of three districts per year, depending on the rate of programme implementation. Moreover, various activities will be carried out in the areas of epidemiological surveillance, awareness-raising and social mobilization, and monitoring and evaluation, which will apply to the various components of the integrated health project. Support will also be provided for training and annual retraining of health personnel in the organization, management and monitoring of district activities, as well as in communications techniques. Cisterns and latrines will be installed near the district health centre as an experiment.

43. EPI, currently the most developed activity, will be the main programme component, around which MCH activities will be reorganized, including growth monitoring, CDD and control of acute respiratory infections (ARI). A forward strategy will be used, thus facilitating the provision of services for the mother-child couple both at the level of the health structures and at the village level - during the mobile teams' rounds.

Expanded programme of immunization

44. All the efforts made to increase immunization coverage over the past three years must be continued in order to consolidate what has already been achieved and to improve on the results already obtained. The programme objectives, identified jointly by the Ministry of Health, WHO and UNICEF, will be the following:

(a) To achieve 100 per cent immunization coverage against measles among children under five years of age and to maintain that percentage;

(b) To achieve 95 per cent tuberculosis coverage, 90 per cent coverage against diphtheria, pertussis and tetanus and 90 per cent coverage in the case of "polio 3" among children aged 12 to 23 months, and to maintain those percentages;

(c) To ensure that 90 per cent of women of child-bearing age have received at least two doses of tetanus vaccine and that the fact that they have been immunized is recorded on their card. Particular emphasis will be placed on the effective control of the target diseases, in accordance with the relevant WHO resolutions and the strategies established for the 1990s. The activities in question will be stepped up in areas where there is a risk of exposure. They will also be integrated into other programme activities.

45. The three target groups are: infants up to 1 year of age; school-age children (poliomyelitis/tetanus booster); and women of child-bearing age. Health personnel will have to take advantage of all opportunities to immunize women when they visit prenatal and child-health clinics and when they bring in their children for immunization. Girls at secondary school will also be immunized.

46. UNICEF will provide:

(a) Vaccines, syringes and needles;

(b) Additional immunization equipment and materials;

(c) Logistical support (maintenance of the cold chain and renewal of part of the fleet of vehicles).

Protection of mothers' and children's health

47. MCH activities, which have so far been dispersed and have not been integrated, will be reorganized and restructured as a coherent intervention system, in order to attract mothers to the essential health services with which they themselves, together with their children, must be provided. The services in question must be both accessible and available to them so that at least 85 per cent of pregnant women in the districts covered by the project may receive good-quality prenatal care, and so that the growth of 90 per cent of children under three years of age may be systematically monitored. Screening in order to identify and monitor high-risk pregnancies will be improved, as well as the conditions under which women give birth both at home and at health stations. The concept of birth spacing will be promoted when women visit prenatal and post-natal clinics. Efforts will also be made to reduce protein-calorie malnutrition in pregnant women and children by means of nutrition rehabilitation activities through all the health units of the districts covered by the project. Nutrition-education sessions will also be held.

48. In close co-operation with the United Nations Population Fund (UNFPA) and the World Bank, which provides support in the form of basic equipment and training for traditional birth attendants, UNICEF will provide medical and teaching materials to approximately 60 health stations and 14 mobile teams.

Control of diarrhoeal diseases

49. The recently developed national diarrhoeal disease control programme, which is scheduled for implementation in 1990, is to be added to EPI. The transmission of information to and training of health personnel and women's group leaders, as well as awareness-raising for and education of mothers, will play a prominent role in this programme. The primary objective will consist in:

(a) Reducing the infant mortality associated with diarrhoea by 30 per cent in the first two years;

(b) Increasing access to oral rehydration salts (ORS) at health units and promoting their systematic and correct use by health personnel;

(c) Ensuring that 90 per cent of children under the age of five are treated with ORS in those villages and districts that have village development committees and health informants; and

(d) Encouraging mothers to feed their children during bouts of diarrhoea and to increase their food intake afterwards.

50. The UNICEF contribution will consist in:

(a) Conducting a survey on knowledge, aptitudes and practices among health personnel and mothers;

(b) Supplying ORS to health units;

(c) Setting up six training units to treat diarrhoea in the hospitals of Moroni, Hombo, Fomboni, Domoni and Mitsamiouli and the Catholic Mission in Moroni;

(d) Retraining health personnel; and

(e) Designing and producing teaching materials on ways of preventing diarrhoea and controlling dehydration.

Control of acute respiratory infections

51. A campaign against acute respiratory infections (ARI), the second cause of child mortality and morbidity in the Comoros, has proved indispensable. Controlling these infections depends upon a suitable and efficient system for supplying essential drugs to the health stations. Thus equipped, the stations will be visited more frequently by mothers and will constitute an important component of maintaining and improving EPI coverage at the district level. In this area, the objective will be to ensure:

(a) That 90 per cent of the children suffering from ARI (severe stage) are sent systematically to a doctor in order to receive the correct treatment;

(b) That health personnel and health informants are able to recognize the various degrees of a respiratory infection (slight or serious);

(c) That both geographic and financial access for the population to essential drugs is considerably improved by setting up village pharmacies.

Campaigns will also be held to raise community awareness and to train health personnel.

52. Support will be provided for setting up village pharmacies; 145 such pharmacies will be set up in the period covered by the project, including 48 in 1990 that will be divided among the first five districts. The others will be set up as the project develops. UNICEF will supply the drugs and provide management training for the villagers, and the central pharmacy will be responsible for all logistical matters. The Government has recommended that a network of village pharmacies should be set up at the following levels:

(a) Villages with a health or medical centre;

(b) Villages with a health or rural maternity clinic;

(c) Villages without health structures. Three lists of drugs suited to each of these levels have already been drawn up. The personnel at the health structures prescribe the drugs; in villages without health structures, this role is performed by the informant-liaison official. The village development committee, at least two of whose members will receive prior training, will be responsible for managing the drugs.

Malaria control

53. Continuing the efforts undertaken since 1987 to control malaria, the Government intends to carry on training personnel, to supply diagnostic and therapeutic materials, and to support preventive activities, such as those relating to sanitation and environmental health, the use of mosquito netting and the seeding of larvivorous fish. For its part, UNICEF will take part in awareness-raising for village communities, which up to now has been lacking at the project level. Teaching materials will be developed in order to explain to people the various steps to be taken to prevent or treat malaria. To that end, close collaboration will be established between health workers and the Sanitary Engineering Department.

Nutrition

54. Because of the well-known lack of reliable data in this area, UNICEF will support the conduct of a national survey, starting in 1990, on the nutritional situation of children and women in the Comoros. This survey will serve as a basis for defining a policy in the nutrition sector and drawing up a plan of action. A national multisectoral seminar will be organized. Simultaneously, such practical and coherent interventions as the routine weighing of children by health personnel and the nutritional education of mothers will be introduced systematically in all health structures and at the village level. Nutrition rehabilitation centres will be established in critical zones; they will have a health-training component and, where appropriate, an agricultural centre, staffed by efficient personnel.

Education

55. With a view to improving the quality of primary education, the Government will undertake the rehabilitation of school buildings and classroom equipment, the revision and adaptation of the curricula, and the training and retraining of primary school teachers. A project of the United Nations Capital Development Fund (UNCDF) for the rebuilding of schools might get under way as early as 1990, while the World Bank is concerned with the training and retraining of primary school teachers. UNICEF will provide supplementary equipment for the refitting of classrooms, as well as school supplies and support material for the revision of the curriculum. The health/nutrition dimension will be introduced, on an experimental basis, in 39 primary schools which will also benefit from the installation of cisterns and latrines. The collaboration of other co-operation agencies will be sought so that their interventions might be directed to the same schools as part of a comprehensive and coherent plan of action.

56. Particular emphasis will be placed on the training of Comorian women. To this end, 50 women's literacy centres and 15 home economics schools distributed on the country's three islands will be reinforced. Literacy will thus constitute the

basis of this training, which should subsequently lead to the organization of these women into groups. These groups will promote income-generating activities and will thus enable women to improve their living conditions and those of their families. Activities relating to the production, processing and conservation of local food products and nutritional education will also be reinforced. More than 1,950 women will benefit from this project, to which UNICEF will supply teaching materials, agricultural equipment, logistical support and subsidies for the training of group leaders. The monitors of rural development centres will be called upon to supervise production activities.

57. As far as possible, the primary schools, literacy centres and home economics schools will concentrate their efforts in the same area as the health training activities identified under the health component with a view to ensuring integration and coherence. The Ministries of Education, Health and Production will be called upon to work in close co-operation with the Federation of Comorian Women.

Water supply and sanitation

58. The supply of drinking water to the population remains one of the major priorities of the Comorian Government. During the 1990-1994 programme, UNICEF will lend its support to the implementation of the second water supply project initially envisaged under the current co-operation programme. This water supply project will be carried out in the N'Tsaouéni region, which has 3,000 inhabitants, of whom approximately 70 per cent are women and children. Depending on the availability of funds, interventions might subsequently be directed towards the islands of Anjouan and Moheli, where there is a very serious problem of unsafe water. Seven gravity-flow water systems on those islands will be rehabilitated by refitting the catchments in order to increase the volume of water and by constructing settling tanks and filters to make the water drinkable. This project will benefit approximately 150,000 inhabitants.

59. A campaign will also be undertaken with the support of the political authorities, the media, the Federation of Comorian Women and youth associations to increase awareness of the importance of environmental sanitation. Fifteen health centres and 39 primary schools located on the three islands and covered by the PCH and education projects will be equipped with cisterns to collect rain water and with improved and ventilated latrines. Construction materials (cement, reinforced concrete, pipes and accessories) will be supplied by UNICEF, which will also provide the technical assistance still so essential to the Comoros.

Social mobilization

60. All the projects mentioned above will have a social mobilization component. The activities will be carried out on a large scale and intensively. The Facts for Life programme and the recommendations formulated in 1987 by a consultant will constitute a basis for consideration of the introduction of a strategy to reinforce the promotion of child survival and development. A multisectoral information and education committee will be established with the active participation of Comorian artists and intellectuals who recently participated in the Antananarivo Symposium. Close collaboration will be established with the communication project financed by UNFPA and the Food and Agriculture Organization of the United Nations (FAO).

Monitoring and evaluation

61. During the period 1990-1994, a permanent system will be set up for monitoring the progress of activities carried out in the field. Performance and impact indicators will be established from the first year of the project to ensure better programme monitoring and to measure the effects on the population. Regular supervisory missions will be undertaken by the national officials responsible for the various services concerned and by UNICEF staff. Periodic reports will be prepared.

62. An annual review of projects will be organized before the plan of action for the following year is prepared. Some of the aims of this review will be to measure the effectiveness of the strategies adopted and the real impact of the activities carried out, and to draw up an inventory of the problems encountered and, if necessary, make adjustments.

Co-ordination with co-operation agencies

63. Throughout the 1990-1994 programme, the dialogue initiated during the preparation of the current recommendation will be maintained and reinforced. Consultation meetings and joint visits to the field will be organized. The programme will have the support and collaboration of the following agencies and donors: UNDP, WHO, UNFPA, FAO, UNCDF, the World Bank, CARE, Caritas, the Centre d'étude et de co-opération internationale, the Rotary Club, the Catholic Mission, the Peace Corps, Laval University, the European Development Fund, and French co-operation.

COMOROS

Basic data: 1988 and earlier years			UNICEF country classification
Under-five mortality rate	129	(1988)	High U5MR
Infant mortality rate	79	(1988)	High IMR
GNP per capita	$370	(1987)	Low GNP
Total population	1 million	(1988)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1988
Births	(thousands)	13	18	21	22
Infant deaths (under 1)	(thousands)	1	2	2	2
Under-five deaths	(thousands)	2	3	3	3
Under-five mortality rate (per 1,000 live births)		165	152	137	129
Infant mortality rate (under 1) (per 1,000 live births)		101	93	84	79

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1980)	Moderate & severe	30*	..
	Severe	8*	..
Babies with low birth weight (%, 1986)		..	14*
Children completing primary level (% of first grade, 1980/1986)		65*	31

NUTRITION INDICATORS		About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%)		.. /../..	.. /../..
Prevalence of wasting (%)		..	..
Prevalence of stunting (%)		..	..
Daily per capita calorie supply (% of requirements, 1979-1981/1984-86)		89	90
Food production per capita index (Index 1979-1981=100, 1980/1986)		105	97
Household expenditure (% of total income)	All food/cereals	.. /..	../..

HEALTH INDICATORS		About 1980	Most recent
ORS use rate (%, 1986-1987)			13
Access to health services (% of population, 1983)	Total	..	82*
	Urban/rural	.. /..	../..
Access to safe water (% of population, 1980)	Total	28*	..
	Urban/rural	53*/20*	../..
Access to adequate sanitation (% of population)	Total	..	..
	Urban/rural	.. /..	../..
Births attended by trained personnel (%, 1981/1988)		24	24
Maternal mortality rate (per 100,000 live births, 1980)		50	..

Immunization		1981	1985	1987	1988
One-year-olds (%) immunized against:	Tuberculosis	..	56	..	95
	DPT	..	31	71	82
	Polio	..	31	73	78
	Measles	..	18	71	85
Pregnant women (%) immunized against	Tetanus	..	8	26	59

COMOROS

Basic data: 1988 and earlier years			UNICEF country classification
Under-five mortality rate	129	(1988)	High U5MR
Infant mortality rate	79	(1988)	High IMR
GNP per capita	$370	(1987)	Low GNP

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net)	Total	93/..	80/59
(%, 1980/1987)	Male	109/..	90/66
	Female	78/..	70/52
Secondary enrolment ratio (gross/net)	Total	24/..	30/..
(%, 1980/1987)	Male	31/..	36/..
	Female	16/..	24/..
Adult literacy rate, 15 years & older	Total	48	..
(%, 1980)	Male/female	56/40	../..
Radio/television sets (per 1,000 population, 1987)		.. /..	112/..

DEMOGRAPHIC INDICATORS		1970	1980	1985	1988	2000**
Total population	(millions)	0.3	0.4	0.4	0.5	0.7
Population aged 0-15 years	(millions)	..	0.2	0.2	0.2	0.3
Population aged 0-4 years	(millions)	..	0.1	0.1	0.1	0.1
Urban population (% of total)		11	23	25	27	34
Life expectancy at births (years)	Total	46	49	51	52	57
	Male/female	45/47	47/51	49/53	50/54	55/59
Total fertility rate		6.3	6.3	6.2	6.2	5.6
Crude birth rate (per 1,000 population)		47	46	46	46	42
Crude death rate (per 1,000 population)		19	17	15	14	11

		About 1980	Most recent
Contraceptive prevalence rate (%)		..	..
Population annual growth rate	Total	3.3*	3.1
(%, 1965-1980/1980-1988)	Urban	4.3*	4.9

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate (%, 1965-1980/1980-1987)		..	..
Inflation rate (%, 1980-1987)		..	7
Population in absolute poverty (%)	Urban/rural	.. /..	../..
Household income share (%)	Top 20%/bottom 40%	.. /..	../..
Government expenditure	Health/education	.. /..	7/25
(% of total expenditure, 1987)	Defence	..	4
Household expenditure (% of total income)	Health/education	.. /..	../..
Official development assistance:	US$ millions	..	..
	As % of GNP	..	..
Debt service (% of goods & services exports, 1980/1987)		2	4

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

TABLE 1. BREAKDOWN OF ACTUAL EXPENDITURE FOR GENERAL RESOURCES AND SUPPLEMENTARY FUNDING UNDER PREVIOUS CO-OPERATION PERIOD, 1987-1989

(Thousands of United States dollars)

COUNTRY: COMOROS
LATEST BOARD APPROVAL: 1987
GENERAL RESOURCES: $800,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	SF	GR	SF	GR	SF	GR	SF	GR	SF	Total
Health	270	159	15	3			18	43	304	205	508
Water supply and sanitation		124				99		126		349	349
Nutrition							2		2		2
Community organization and development							34	9	34	9	43
Emergency		5								5	5
Planning and project support	28				139	67	71	2	238	69	307
Freight	46	88							46	88	134
GRAND TOTAL	344	377	15	3	139	166	126	179	624	725	1349

GR = General resources.
SF = Supplementary funding.

TABLE 2. PLANNED EXPENDITURE FOR GENERAL RESOURCES, NEW SUPPLEMENTARY FUNDING AND FUNDED SUPPLEMENTARY FUNDING

(Thousands of United States dollars)

Country: COMOROS Period covered: 1990-1994	Funding status	1990	1991	1992	1993	1994	Total
Health							
Other health	GR	91	130	138	129	99	587
	FSF	43					43
	NSF	273	181	197	189	103	943
Subtotal, health	GR	91	130	138	129	99	587
	FSF	43					43
	NSF	273	181	197	189	103	943
Water supply and sanitation	GR	6					6
	NSF	361	528	510	418	225	2043
Nutrition	GR	60	26				86
	FSF	50					50
Education	GR	17	17	29	39	59	160
	NSF	101	110	127	127	120	584
Planning and project support	GR	127	127	133	132	142	661
TOTAL	GR	300	300	300	300	300	1500
	FSF	93					93
	NSF	734	820	834	734	448	3570
GRAND TOTAL		1127	1120	1134	1034	748	5163

GR = General resources.
NSF = New supplementary funding.
FSF = Funded supplementary funding.

TABLE 3. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: COMOROS	Number of posts	1990-1991 amount (Thousands of US dollars)
FINANCED FROM 1990-1991 APPROVED BUDGET:		
International Professional established posts		
Local national Professional and General Service established posts	2	35
Operating costs		a/
Total	2	35
FINANCED FROM PROGRAMME FUNDS: b/		
International Professional project posts		
General resources	1	140
Supplementary funds	1	140
Local national Professional and General Service project posts		
General resources	2	30
Supplementary funds	3	35
Total	7	345

a/ Included in Madagascar area office budget.
b/ For information source, see 1990 post authorization table, revised October 1989.